



DEPARTMENT OF CORRECTIONS Human Resources



Title:	Management of Injured Workers	DOC Policy: 20.5.17
Effective:	6/12/06	Supersedes: 9/2/03
Applicability: All Department of Corrections Employees		
Directives Cross-Reference: None		
Attachments: SAIF Claims Management, Flow Chart DOC Employee Medical Status Report (CD1422) DOC Job Description for Temporary Transitional Work Letter A, Time-Loss Payments Letter B, No Time-Loss Payments Letter C, Interim Review and/or Changes in Restrictions Letter D, Off-the-Job Injury Letter E, End of Temporary Modified Duty Employee/Volunteer Report or Incident/Near-Miss/Injury/Illness Supervisor's Analysis of Incident/Near-Miss/Injury/Illness Continuation of Benefits Employee Notice		

I. PURPOSE

The purpose of this policy is to establish a Department of Corrections program to return an employee with a compensable work-related injury or illness to an available and suitable position as soon as possible. This program will include provisions for an Early-Return-To-Work (ERTW) program (temporary transitional work/modified duty work) when appropriate and available while the employee is recovering from the on-the-job injury or illness. ERTW guidelines may be applied to employees who sustain an off-the-job injury if temporary modified work is available and appropriate (See Section IV, Policy Clarification, A.).

II. DEFINITIONS

- A. Available reinstatement** means the injured employee's job at the time of injury/illness, if the position exists, and the employee is released by the treating physician back to his/her regular position regardless of the hiring or assignment of a replacement worker to that position. If the former position no longer exists, the employee will be reinstated in another existing position that is vacant and suitable. Rights of reinstatement will be subject to the provisions for seniority rights and other employment restrictions contained in valid collective bargaining agreements.
- B. Available Reemployment** refers to another existing position that is vacant and suitable if the employee is disabled from performing the duties of his/her former regular position. Rights of reemployment will be subject to the provisions for seniority rights and other employment restrictions contained in valid collective bargaining agreements.
- C. Early-Return-to-Work (ERTW)** is a program and process of returning an on-the-job injured employee to a transitional work assignment or temporary modified

duty as soon as possible after the treating physician provides a modified duty or restricted duty work release, provided that temporary modified work is available, suitable, and/or appropriate. (See Section IV, Policy Clarification, B.).

- D. Suitable reinstatement employment** is the position held at time of injury if the employee is not disabled from performing the duties of that position or if that position no longer exists, an existing and vacant position that is most similar to the former position in compensation, duties, responsibilities, skills, location, duration, and shift. Please see Available reinstatement above.
- E. Suitable reemployment** is an existing and vacant position that meets the injured employees' medical restrictions and for which the employee is qualified to perform the essential functions of the position, with or without accommodation. A suitable position is as similar as practical to the former position in compensation, duties, responsibilities, skills, location, duration, and shift and is within the same or lower salary range as the position held at time of injury. A suitable reemployment position is paid at the rate provided for in the compensation plan for that position. Please see Available reemployment above.
- F. Transitional work assignments or temporary modified work** is designed to give an employee meaningful work while continuing to heal from an injury or illness. These are not permanent assignments or duties, but transitional work or modified duty assignments designed to meet temporary restrictions placed on the injured employee by the treating physician.

III. POLICY

It is an unlawful employment practice to discriminate against an employee (permanent or temporary) or potential employee with respect to hire, tenure, or any term or condition of employment because the individual has applied for Workers Compensation benefits, invoked, or utilized the procedures provided for in ORS Chapter 656 or has given testimony under the provisions of those laws.

A. Early Return to Work (ERTW):

1. The Department of Corrections shall endeavor to return an on-the-job injured employee to temporary transitional work or modified duty within three working days of an injury, illness, or attending physician's release.
2. The assigned safety manager, in consultation with the on-the-job injured employee's supervisor, will follow the procedures as outlined in Attachment A, "SAIF Claims Management".
3. Temporary transitional or modified duty is typically limited to 30 days. With continued improvement, 30-day extensions are possible but generally ERTW is limited to total of 90 days. During these 30-day extension periods employees shall provide an updated Employee Medical Status Report (within Attachment A) or a treating physician generated medical status statement. Extensions over 90 days may be granted due to major changes in claim status that have occurred during the present temporary modified duty such as surgery, but the Departments Administrator of Safety & Risk must approve all extensions. Extensions of transitional work or modified duty are limited to 30-day increments or less and will not exceed a total of an additional 90 days due to a major

change in claim status. An employee who is not released to return to full unrestricted duty (full release from the attending physician) after completing 90 days of a temporary modified duty assignment (barring possible extensions) will be placed on leave.

4. An employee who has filed a claim for workers' compensation benefits and is in temporary transitional work or temporarily modified duty will receive the same salary or rate of pay at time of injury, including any differentials during the transitional work period, regardless of shift, location, etc, of the transitional work.

B. Workers' Compensation - Reinstatement/Reemployment

1. Reinstatement of the employee to the position at time of injury will be in accordance with the ORS 659A.043, "Reinstatement of injured worker to former position; certificate of physician evidencing ability to work; effect of collective bargaining agreement; termination of right to reinstatement; when reinstatement right terminates".
2. Reemployment of an injured worker who is disabled from returning to his/her former position will be done in accordance with ORS 659A.046, "Reemployment of injured worker in other available and suitable work; termination of right to reemployment; certificate of physician; effect of collective bargaining agreement". The Department's Administrator of Safety & Risk shall determine suitable and available reemployment options.

C. Statewide Injured Workers List (entry level positions)

1. An employee with a compensable claim who cannot be reinstated or reemployed within the Department of Corrections shall be placed on the Statewide Injured Workers List by the Department's Human Resources Recruitment Division unless the employee is ineligible for placement on such list (see # 3 below).
 - a. The injured employee shall provide a current detailed PD-100 to the Department's Administrator of Safety & Risk when it has been determined that the injured employee cannot be reinstated or reemployed within the Department of Corrections.
 - b. The Department of Corrections, Human Resources Recruitment Division shall determine the appropriate classifications based on the supplied PD-100 from the injured employee for posting on the Statewide Injured Worker List.
2. The Department's Human Resources Recruitment Division will remove the injured worker's name from the Statewide Injured Workers List when notified that the worker is no longer eligible for placement or retention on this list (see #3 below).
3. An injured employee shall be ineligible for placement or retention on the State Wide Injured Worker List when the employee has:
 - a. Refused appropriate modified duty;
 - b. Declined interviews;

- c. Declined offers of suitable employment;
- d. Retired;
- e. Terminated for cause;
- f. Lost reemployment/reinstatement rights for any reason defined under ORS 659A.043 or ORS 659A.046;
- g. Otherwise separated from state service;
- h. Failed to notify the agency of injury of changes in address, telephone number, return to work status, or medical status; or
- i. Been on the list more than three years from the date of injury.

D. Continuation of Benefits

- 1. The Department will follow the requirements of OAR 659A.063, "State to continue group benefits for injured worker and covered dependents; when ended".
- 2. Any collections due to overpayment will be enacted in accordance with any applicable collective bargaining agreement, DOC Policy, State of Oregon payroll rules and/or policy, and/or any other applicable OAR or ORS. (Listing order does not construe order of process).

E. Filling a Vacancy

When filling a vacant classification, the Department of Corrections Human Resources Recruitment Division will:

- 1. Check the State Wide Injured Worker List of qualified injured workers of the appropriate class; and
- 2. Offer the position to the qualified injured worker who has been on the State Wide Injured Worker List the longest, if qualified for the position; and
- 3. Notify the agency-of-injury if the injured worker fails to respond or accept the position. The recruitment unit may code the State Wide Injured Worker List with the disposition code that indicates the employee's failure to respond or refusal of the job.

F. Employees will:

- 1. Report all accidents, incidents, near-miss, and work-related injuries/illness to the supervisor immediately or no later than the end of the work shift whether or not medical care is received or anticipated. If the immediate supervisor is not available, the report will be made to the next level supervisor or the assigned safety manager; and
- 2. If involved in an accident/incident and/or a near-miss complete an "Oregon Department of Corrections Employee/Volunteer Report of Incident/Near-Miss/Injury/Illness" form CD 1381 (5/02) (attached) to document the accident, incident, injury, illness and/or near-miss that may have occurred during the work shift and forward it immediately upon completion to the supervisor; and

3. Complete a SAIF Corporation 801 Claim form (U:/General-Information/Forms/Safety-Forms, or U:/Human-Resources/Safety & Risk/Safety-Form-Shortcut or downloadable from www.SAIF.com under "Filing a Claim") to file a claim for workers' compensation benefits for an on-the-job injury/illness if the employee has received or intends to receive medical attention and the employee intends to file a claim for workers' compensation benefits (See Section IV, Policy Clarification, C.). This form must be completed immediately or within 24 hours of the time the employee knows he/she will be seeking medical treatment for an on-the-job injury/illness. If the employee has filed a SAIF 827 "Worker's and Physician's Report for Worker's Compensation Claims" at his/her treating physician's office, then the employee will also complete a SAIF 801 form and immediately forward to the assigned safety manager. All SAIF claims will be submitted to SAIF five days from the employer's date of knowledge of the claim. The employee is responsible for completing the SAIF 801 form and forwarding it to the assigned safety manager or designee (if the safety manager is unavailable) for submission to SAIF within this time limit; and
4. Provide the assigned safety manager and/or designee with a medical status report prepared by the attending physician (Within Attachment A or treating physician generated medical status_statement) within 24 hours of medical treatment. These medical status report(s) will contain only specific and objective information such as; employee capabilities, limitations, and prognosis so that the assigned safety manager in consultation with the supervisor may determine if there is any temporary modified duty work available; and
5. When off work due to an on-the-job injury, contact the assigned safety manager or designee every week (calling in weekly is normally limited to a four week time period of time loss) to report his/her medical condition. Employees who are off work for extended periods (four weeks or longer) shall contact the assigned safety manager or designee whenever there is a change in medical conditions that affect the return-to-work status. Employees shall also provide physician updates after claim related doctor visits, such as employee capabilities, limitations, and prognosis, so the assigned safety manager in consultation with the supervisor may determine an appropriate transitional work or modified duty assignment when the employee is released to such work; and
6. Provide the assigned safety manager and supervisor with a current phone number, even an unlisted one, and address; and
7. Cooperate with the assigned safety manager, their supervisor, human resource manager, and/or SAIF Corporation in efforts to identify appropriate modified duty assignments and/or available and suitable work, and report for duty to such assignments; and
8. Be subject to initiation of employment disciplinary processes through failure to cooperate in this program as outlined in this policy.

G. Supervisors will:

1. Investigate all accidents and/or incidents with the aid of the affected employee and/or the assigned safety manager; and
2. Complete the "Oregon Department of Corrections Supervisor's Analysis of the Incident/Near-Miss/Injury/Illness" form CD 1381 (5/02) as soon as it is completed by the employee and provided to the supervisor, and distribute as noted on the form; and
3. Forward the SAIF 801 form to the assigned safety manager for completion (if delivered to the supervisor); and
4. Review the ERTW process with the employee; and
5. Immediately contact the assigned safety manager to initiate the ERTW program when the treating physician releases the on-the-job injured/ill employee to temporary modified work.

H. Assigned Unit Safety Managers will:

1. Complete the SAIF 801 form, forwarding it to SAIF Corporation within five days of knowledge of a claim, and provide a copy to the Department's Administrator of Safety & Risk; and
2. Initiate the ERTW process following the SAIF Claims Management Flow Chart (Attachment A); and
3. Work with the injured worker's supervisor to locate and provide temporary modified transitional work when available and appropriate; and
4. Maintain and provide copies of all approved physician signed job descriptions and letters of job offer to the Department's Administrator of Safety and Risk; and
5. Notify the East or West FMLA/OFLA coordinator when a claim results in time-loss; and
6. Be the liaison between the treating physician and the department; and
7. Be the liaison between SAIF Corporation and the department; and
8. Notify the Department's Administrator of Safety and Risk when an employee who has sustained a compensable injury and is disabled and/or permanently restricted from performing the duties of the worker's position at time of injury; and
9. Utilize the Workers' Compensation Division's Employee-At-Injury-Program (EAIP) in all applicable situations; and
10. Review the "Oregon Department of Corrections Supervisor's Analysis of the Incident/Near-Miss/Injury/Illness" form CD 1381 (5/02), working with the supervisor to prevent re-occurrences and/or to correct hazardous conditions; and

11. Consult with the Department's Administrator of Safety & Risk in working with the Preferred Worker Program.

IV. POLICY CLARIFICATION

A. Early-Return-To Work and Off-the-Job Injuries:

1. Transitional work assignments or temporary modified work provisions as outlined in III Policy, A, Early Return to Work (ERTW), 2, 3, may be used for off-the-job injured employees if it is possible and/or appropriate to return the off-the-job injured employee to temporary modified work.
 2. Employees seeking temporary transitional work or modified duty for an off-the-job injury/illness will provide an "Employee Medical Release Authorization" (within ODOC Medical Status Report, or similar document) prior to any temporary work job offer. This release shall not be construed as a general release of medical information but as an authorization that the employee and treating physician can provide only information necessary to return the off-the-job injured employee to a temporary transitional modified work assignment.
 3. The on-the-job injured employee has a higher priority for placement in transitional assignments or temporary modified work and could displace an off-the-job injured employee if there is not sufficient work for both.
 4. The rate of compensation (pay) for an off-the-job injured employee working in transitional work or modified duty shall be determined by the assigned Human Resources Manager in consultation with the employee's supervisor.
- B. The Department of Corrections has neither the duty nor legal authority to create a position for returning an injured employee back to work.
- C. Employees have the legal right not to file a claim for workers' compensation benefits if they so choose. Refusal to sign or file a claim form for an on-the-job injury will be documented by the assigned safety manager and the employee's supervisor. **Note: The Department of Corrections encourages all employees who suspect that they were injured on-the-job to file a claim for workers' compensation benefits.**

V. IMPLEMENTATION

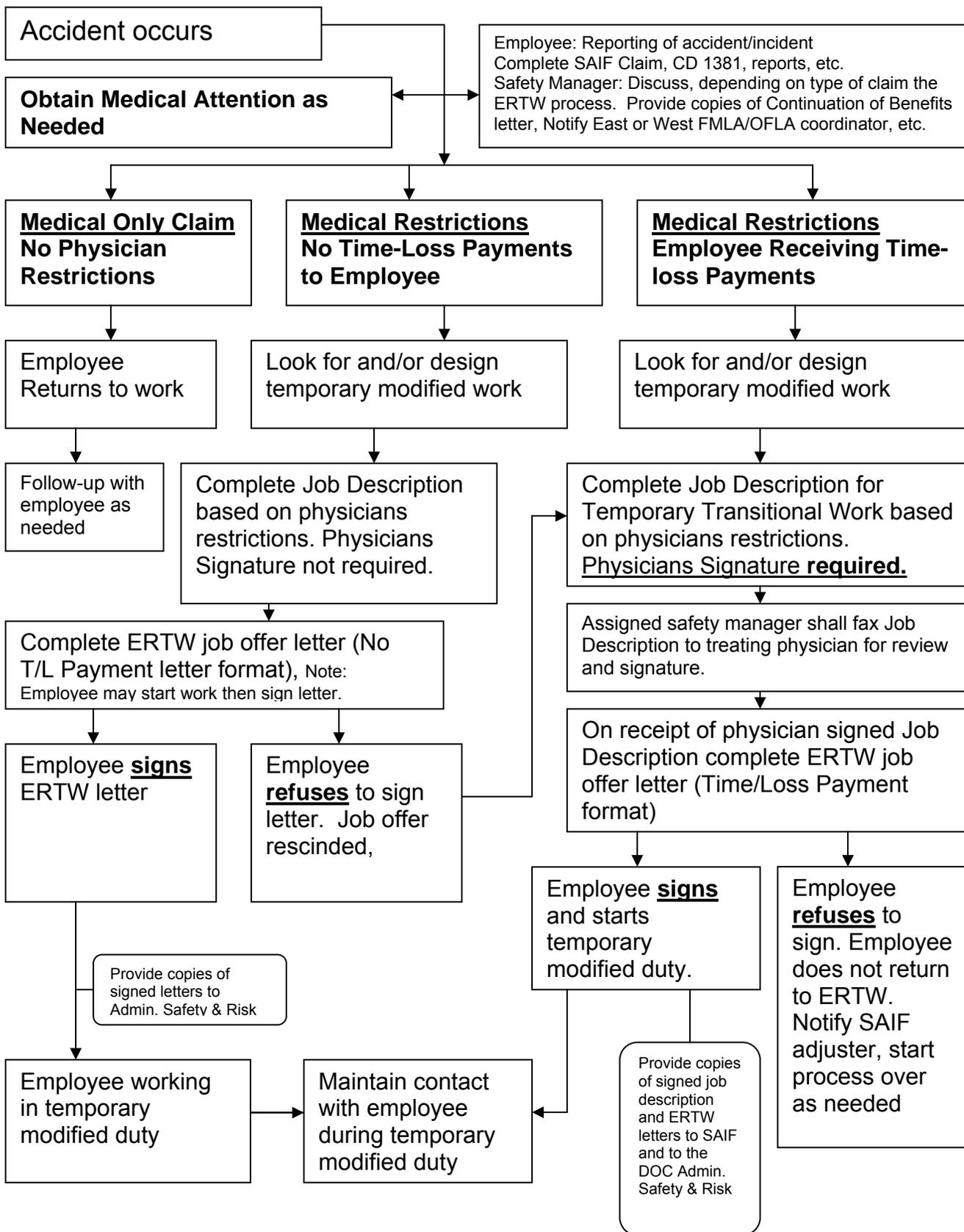
This policy will be adopted immediately without further modification.

Certified: Signature on File
Birdie Worley, Rules Coordinator

Approved: Signature on File
Mitch Morrow, Deputy Director

SAIF Claims Management, Flow Chart (simplistic)

Attachment A



The following is a general outline concerning the process of managing a workers' compensation claim involving medical restrictions from the employees treating physician.

Forms/Letters

SAIF 801, "Report of Job Injury or Illness, Workers" Compensation Claim"

This form is normally used to file a claim for workers' compensation benefits. It may be obtained at: U:/General-Information/Forms/Safety-Forms, or U:/Human-Resources/Safety & Risk/Safety-Form-Shortcut or downloadable from www.SAIF.com under "Filing a Claim". An "801" form is not to be used to document an accident/incident and/or an injury/illness but only used to file a claim for benefits through workers' compensation.

DOC Employee Medical Status Report, CD 1422 rev. 9/03

This form is provided for the physician to use to list capacities and/or restrictions and then returned to the assigned safety manager to provide details so that temporary modified duty may be provided. Employees should provide this form to their physician at their initial and subsequent visits when seeking medical care from an on-the-job injury or illness. If an employee is seeking temporary modified duty for an off-the-job injury/illness the "Employee Medical Release Authorization" must be signed by the employee. The off-the job injured employee will provide the necessary copies of this release to all of the applicable individuals.

DOC EMPLOYEE/VOLUNTEER REPORT OF INCIDENT/NEAR-MISS/INJURY/ILLNESS, CD 1381 5/02

This form is used to document accidents, injuries, etc that occur at the workplace. All employees are required to complete this form if there is an accident or injury. Documentation of injuries is an integral part of workers' compensation claim management. Undocumented injuries can be denied if the claim was filed six months or longer after the injury, whereas with a documented injury a claim may be filed for up to a year after the incident.

Job Description for Temporary Transitional Work

This form is used by the safety manager to define the parameters of the temporary Early-Return-To-Work job offer. This job description takes into account the physician's medical restrictions. The physician's signature of approval is dependent on the type of claim, i.e., time-loss or no time-loss.

Transitional/Modified Duty Return to Work Letter, Letter A, Time/Loss Payments

This letter is used to document the parameters of temporary modified duty assignment when an injured employee has been receiving time-loss payments. A physician signed job description will be attached. This is considered a bona fide temporary job offer and failure to accept could affect benefits provided under workers' compensation. Note: The content of this letter is defined by statute and items/content may not be changed or deleted.

Transitional/Modified Duty Return to Work Letter, Letter B, No Time/Loss Payments

This letter is used to document the parameters of temporary modified duty assignment when an injured employee is not receiving time-loss payments. A job description will be attached (no physician signature required). This is not considered a bona fide temporary job offer and failure to accept will not affect benefits provided under workers' compensation.

Transitional/Modified Duty Return to Work Letter, Letter C, Interim review and/or changes in restrictions (30, 60 day letters, etc.)

This letter is used to document any changes in the temporary modified duty assignment when and if the temporary duty extends beyond 30 days or when medical restrictions change. It may or may

not have a new job description. This letter format of this letter may be changed depending on the type of interim review. For use at the 60 day extension the sentence “Your temporary transitional/modified duty work will end on _____, at that time without a full unrestricted release from your treating physician you will be placed on leave.” shall be added. A modified format of this letter may be used to extend/modify for off-the-job temporary modified duty (remove reference to a SAIF claim, etc.).

Transitional/Modified Duty Return to Work Letter, Letter D, Off-the-Job Injury

This letter is used to document the parameters of temporary modified duty assignment for an off-the-job injured employee. A job description will be attached (no physician signature required).

Transitional/Modified Duty Return to Work Letter, Letter F, End of Temporary Modified Duty

This letter is use to end temporary modified duty. Ending of temporary modified duty may occur at any time during the temporary modified duty based on medical restrictions, the condition of the injured employee, availability of work, etc. Normally temporary modified duty ends at the 90 day mark. The format of this letter can be modified to accommodate the conditions of the claim. A modified format of this letter may be used to end temporary modified duty for off-the-job injured employees, i.e. remove reference to a SAIF claim, etc.

Continuation of Benefits Letter

This notice is provided by the safety manger to the employee on time-loss to explain ORS 659A.060 – 659A.069 which requires the State as an employer to continue to pay the employer’s contribution towards group health benefits for one year from the date-of-injury if the individual is on time loss. This notice is to be completed by the employee and returned to the Human Resources Pay Roll and Benefits Division.

Medical Restrictions No Time-Loss Payments being received by Employee

- A. Taking the physicians restrictions into consideration the first choice is to see if the existing position/work can be temporarily modified to accommodate the injured worker. If that is not possible, then other work locations should be considered as possible temporary modified duty work locations.
- B. When a temporary modified duty location has been found a job description of this temporary modified duty should be completed based on the physician’s restrictions using the form provided in this attachment (Job Description for Temporary Transitional Work). This form does not have to be signed by the treating physician.
- C. Complete an ERTW letter using the Transitional/Modified Duty Return to Work Letter, Letter B No Time-Loss Payments, attach job description, and have employee sign and report to the temporary transitional work assignment. Note: If the employee verbally accepts the temporary modified job offer (noted by the safety manager) the modified duty ERTW letter with the attached job description may be signed after the employee starts the temporary modified duty.
- D. If the employee refuses to accept temporary transitional modified duty or sign the ERTW letter, the job offer should be rescinded. The assigned safety manager shall fax the completed job description to the treating physician for his/her signature.
 - a. On receipt of a physician signed job description, an ERTW letter using the Transitional/Modified Duty Return to Work Letter, Letter A, Time-Loss Payments, shall be completed. Attach the signed job description, and have employee sign.
 - b. If the employee signs the ERTW letter have him/her report to the temporary modified duty assignment.
 - c. If the employee refuses to sign and accept the temporary modified duty assignment the temporary job assignment offer will be rescinded. The assigned safety manager will contact

the assigned SAIF claim adjuster and the Department's Administer of Safety and Risk to discuss options.

- E. The safety manager and supervisor should maintain communication and contact with the injured employee during the temporary modified duty.
- F. The appropriateness and continuation of the temporary modified duty shall be reviewed at the 30 and 60 day intervals. At the 60 day review the employee shall be notified that the temporary modified duty will normally end at the 90 day mark, and unless the employee has a full unrestricted release he/she will be placed on leave.

Medical Restrictions Employee Receiving Time-Loss Payments

- A. Taking the physicians restrictions into consideration the first choice is to see if the existing position/work can be temporarily modified to accommodate the injured worker. If that is not possible, then other work locations should be considered as possible temporary modified duty work locations.
- B. When a temporary modified duty location has been found a job description of this temporary modified duty should be completed based on the physicians restrictions using the form provided in this attachment (Job Description for Temporary Transitional Work). This form is to be signed by the treating physician.
- C. On receipt of a signed Job Description from the treating physician, complete an ERTW letter using the Transitional/Modified Duty Return to Work Letter, Letter A Time-Loss Payments and attach the physician signed Job Description.
- D. If possible call and ask the employee to come in and sign the ERTW letter and to discuss the ERTW process, the physician's approval of the Job Description, the temporary modified duty work assignment, etc. If you are unable to contact the employee by phone the ERTW letter should be mailed regular and certified to the employee.
- E. On signature of the ERTW letter by the employee, the employee should start work in the temporary transitional/modified work as the letter indicates.
- F. If the employee refuses to accept the temporary transitional modified duty or sign the ERTW letter, the job offer should be rescinded. Call the assigned SAIF adjuster and the Department's Administrator of Safety & Risk to notify of refusal by the employee and to discuss options.
- G. The appropriateness and continuation of the temporary modified duty shall be reviewed at the 30 and 60 day intervals. At the 60 day review the employee shall be notified that the temporary modified duty will normally end at the 90 day mark and unless the employee has a full unrestricted release, he/she will be placed on leave.



**OREGON DEPARTMENT OF CORRECTIONS
Employee Medical Status Report**

The Oregon Department of Corrections provides a transitional-work program for short-term, medically restricted employees who have experienced injury or illness on or off the job. This temporary transitional work program is designed to provide transitional work, as approved by the treating physician and as appropriate for the employee's temporary physical limitations and/or restrictions. Transitional work is normally limited to 30-days with possible extensions after review, but at no time shall transitional-work extend beyond 90 days. The employee is expected to adhere to the treating physician's restrictions. The supervisor monitors for compliance with the transitional-work program.

NOTE: IF THIS IS AN OFF-THE-JOB INJURY OR ILLNESS THE EMPLOYEE MUST SIGN THE "EMPLOYEE MEDICAL RELEASE AUTHORIZATION" ON PAGE 2.

1. Employee Information:

Name: _____ Date of Injury/illness: _____

2. Return to Work Status:

PLEASE CHECK APPROPRIATE STATUS (ONE ONLY):

_____ May return to regular job (complete items 5 - 8) Date: _____

_____ May return to transitional/modified duty (complete items 1 – 8) Date: _____

_____ May not return to any work (complete items 5 - 8)

Estimated date of return: _____

3. Temporary Physical Limitations: (No comment indicates no limitation)

C = Continuous, no limit, 66% to 100% of the day

F = frequently, 34%-65% of the day

O = occasionally, up to 33% of the day

N = Not OK

Capabilities	C	F	O	N	Lifting	C	F	O	N
Bend					0-10 lbs.				
Squat					11-20 lbs.				
Crawl					21-40 lbs.				
Twist					41-60 lbs.				
Reach above shoulders					Over 60 lbs.				
Walk ramps					Use arms/repeated pushing/pulling				
Use stairs/steps/step-stools					Use arms/repeated grasp/lift/carry				
Use ladders					Use hands/repeated fine manipulations				
Run/Walk on rough/uneven surfaces					Carry: (max. lbs. Ok?)				
Run or jog up to 200 yards									
Push or pull loads up to 175 lbs.									
Pull, drag, or carry loads with an average weight of 162 lbs. for a distance up to 40 yards									
Operate a motor vehicle									

Please be aware that "no inmate contact" is **not** a statement of physical limitation. Providing an accurate assessment of physical limitations permits us to determine a safe work assignment for the employee. A "no inmate contact" limitation prohibits the employee from working anywhere in the institution or possibly on any DOC grounds. There is potential for inmate contact within an institution going to and from restrooms, staff dining rooms, or locker rooms. There may also be incidental contact with inmate orderlies at any DOC facility.

4. Endurance:

Please indicate below the number of hours these activities should be limited to.

Hours	1	2	3	4	5	6	7	8
Sitting								
Standing								
Walking								

Total number of hour's patient may work per day: _____ Per Week: _____

5. Medically Stationary Yes ___ No ___: Permanent Physical Restrictions (list):

6. Physician's Comments or Suggestions: _

7. Date of Next Appointment: _____

8. Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

The information on this form will be kept confidential, except that supervisors and managers may be informed regarding restrictions on the work or duties of employees. Agency medical consultants and safety personnel may be informed where appropriate if a condition requires emergency treatment. Government officials investigating compliance with the law shall be provided relevant information upon request.

Employee Medical Release Authorization

I HEREBY AUTHORIZE the addressee below to release the medical information requested on this form which is relevant to work capacity and/or performance. I EXPECT THIS INFORMATION TO BE TREATED IN THE STRICTEST OF CONFIDENCE and used only to determine what temporary or permanent modifications may be made for my work assignment.

Employees Signature: _____ Date: _____

Physician Addressee: _____ Phone Number: _____

Address: _____

Street or PO Box

City

State

Zip

**Oregon Department of Corrections
Job Description for Temporary Transitional Work**

Employee Name:
Address:
City, State, Zip

SAIF Claim No.:
Date of Injury:

Employer:	Contact Person:
Address:	Phone No.:
FAX No.:	

Job Title of Worker:
Location of Transitional Work:

Job Duties:

Endurance	Never: 0 hrs (per day)	Occas.: 1-3 hrs (per day)	Freq: 3-6 hrs (per day)	Cont.: 6-8 hrs (per day)	Total hours in work day
Sitting					
Standing					
Walking					

Lift	Never 0 hrs	Occas. 1-3 hrs	Freq. 3-6 hrs	Cont. 6-8 hrs
1-10 lbs				
11-20 lbs				
21-50 lbs				
51-75 lbs				
76-100 lbs				

Carry	Never 0 hrs	Occas. 1-3 hrs	Freq. 3-6 hrs	Cont. 6-8 hrs
1-10 lbs				
11-20 lbs				
21-50 lbs				
51-75 lbs				
76-100 lbs				

Push	Never 0 hrs	Occas. 1-3 hrs	Freq. 3-6 hrs	Cont. 6-8 hrs
1-10 lbs				
11-20 lbs				
21-50 lbs				
51-75 lbs				
76-100 lbs				

Pull	Never 0 hrs	Occas. 1-3 hrs	Freq. 3-6 hrs	Cont. 6-8 hrs
1-10 lbs				
11-20 lbs				
21-50 lbs				
51-75 lbs				
76-100 lbs				

	Never 0 hrs	Occas. 1-3 hrs	Freq. 3-6 hrs	Cont. 6-8 hrs
Bend				
Twist				
Crouch				
Kneel				
Walk-Level surface				
Walk-Uneven Surface				
Climb Stairs				
Climb Ladder				
Reach Above Shoulder				
Repetitive Use Arms				
Repetitive Use Wrist				
Repetitive Use Hands				
(a) Grasping				
(b) Squeezing				
Operate Foot Control				
Keyboarding				
Other:				

Environmental	Never 0 hrs	Occas. 1-3 hrs	Freq. 3-6 hrs	Cont. 6-8 hrs
Inside				
Outside				
Heat				
Cold				
Dusty				
Noisy				
Other:				

Additional Comments:

Employer's Representative Signature:	Date:
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FOR PHYSICIAN TO COMPLETE (Please address both questions):	
1. The commute to this job is within the physical capacities of the worker?	Yes _____ No _____
By commute, we mean: can worker tolerate either 1) driving a car, or 2) being a passenger in a car, or 3) utilizing public transportation (to and from home to work location)?	
2. Job Appropriate?	Yes _____ No _____ Date of Release: _____
_____	_____
PHYSICIAN'S SIGNATURE	DATE

Oregon Department of Corrections
Transitional/Modified Duty Return to Work Letter

Letter A, Time/loss Payments



Date:

Name:

Address:

City, State Zip:

SAIF Claim No.:

Date of Injury:

Dear:

Your attending physician, Dr. _____, has released you for modified work. We have located a temporary position for you which your physician feels you will be able to perform successfully. In accordance with DOC Policy 20.5.7 this short-term transitional work assignment is typically limited to a 30-day period with extensions possibly ending at a total of 90 days. The availability of this position will be periodically re-evaluated.

The job is: _____ See attached job description with physician's approval.

You will be receiving the wages you were receiving at the time of your injury. SAIF Corporation may supplement your wages with workers' compensation benefits.

We ask that you report for work on:

Date: _____ Time: _____ (a.m. /p.m.) Shift: _____

Hours per day/week: _____ Duration of job (if known): _____

Report to: _____ Phone: _____

Location: _____

(This location is less than 50 miles from where you were injured or less than 50 miles from where you live.)

If you receive this letter after the start date of this job, the job will begin on the next working day after your receipt of this offer. Immediately upon receipt of this letter, please contact:

While working in this temporary modified duty assignment it is an expectation that you will follow your physician's medical restrictions.

**FAILURE TO REPORT TO WORK COULD AFFECT TIME-LOSS COMPENSATION,
VOCATIONAL ELIGIBILITY AND COULD AFFECT YOUR REINSTATEMENT RIGHTS.**

Please see attached Oregon Administrative Rules concerning your rights and obligations under this offer of transitional/temporary employment. These attached rules are fully incorporated into this job offer.

If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reason(s) for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's action(s) to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282.

We are looking forward to seeing you and wish you a speedy recovery.

Sincerely,

Name & Title:

Department:

Telephone:

I have read and understand the above information. I accept this job as offered.
Yes _____ No _____

Employee Signature

Date

Attachment – OAR 436-060-0030 (5)

OAR 436-060-0030(5) (to be attached temporary modified duty or transitional work letter)

c) The employer or insurer has confirmed the offer of employment in writing to the worker stating:

(A) the beginning time, date and place;

(B) the duration of the job, if known;

(C) the wages;

(D) an accurate description of the physical requirements of the job; and

(E) that the attending physician has found the job to be within the worker's capabilities and the commute within the worker's physical capacity;

(F) the worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:

(i) The offer is at a site more than 50 miles from where the worker was injured, unless the work site is less than 50 miles from the worker's residence, or the intent of the employer and worker at the time of hire or as established by the employment pattern prior to the injury was that the job involved multiple or mobile work sites and the worker could be assigned to any such site. Examples of such sites include, but are not limited to logging, trucking, construction workers, and temporary employees;

(ii) Is not with the employer at injury;

(iii) Is not at a work site of the employer at injury;

(iv) Is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or

(v) Is not consistent with an existing shift change provision of an applicable union contract; and

(G) The following notice, in prominent or bold face type:

“If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reason(s) for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's action(s) to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282.”

Date:

Name:

Address:

City, State Zip:

SAIF Claim No.:

Date of Injury:



Dear:

Your attending physician, Dr. _____, has released you for modified work. We have located or designed a temporary modified duty position for you which meet your physician's restrictions. In accordance with DOC Policy 20.5.7 this short-term transitional work assignment is typically limited to a 30-day period with extensions possible ending at a total of 90 days. The availability of this position will be periodically re-evaluated.

The job is: _____ See attached job description.

You will be receiving the wages you were receiving at the time of your injury. SAIF Corporation may supplement your wages with workers' compensation benefits.

We ask that you report for work on:

Date: _____ Time: _____ (a.m. /p.m.) Shift: _____

Hours per day/week: _____ Duration of job (if known): _____

Report to: _____ Phone: _____

Location: _____

While working in this temporary modified duty assignment it is an expectation that you will follow your physician's medical restrictions.

FAILURE TO REPORT TO WORK WILL NOT AFFECT TIME-LOSS COMPENSATION

We are looking forward to seeing you and wish you a speedy recovery.

Sincerely,

Name & Title:

Department:

Telephone:

I have read and understand the above information. I accept this job as offered. Yes _____ No _____

Employee Signature

Date

Oregon Department of Corrections
Transitional/Modified Duty Return to Work Letter
Interim Review

Letter C, Interim review and/or changes in restrictions



Date:

Name:

Address:

City, State Zip:

SAIF Claim No.:

Date of Injury:

Dear:

This letter is to confirm the extension of your temporary modified duty assignment. Your attending physician, Dr. _____, had released you for modified work and we have provided a temporary modified duty position for you which meet your physician's restrictions.

In accordance with DOC Policy 20.5.7 this short-term transitional work assignment is typically reviewed at 30 and/or 60 day intervals.

30 day review _____ 60 day _____ Other _____

The job is: _____ (Attach Job Description as may be needed)

You were asked to report for work on (any changes should be noted):

Date: _____ Time: _____ (a.m. /p.m.) Shift:: _____

Hours per day/week: _____ Duration of job (if known): _____

Report to: _____ Phone: _____

Location: _____

(60 day notice, ending of temporary modified duty)

Your temporary transitional/modified duty work will end on _____, at that time without a full unrestricted release from your treating physician you will be placed on leave

While working in this temporary modified duty assignment it is an expectation that you will follow your physician's medical restrictions.

We are looking forward to seeing you and wish you a speedy recovery.

Sincerely,

Name & Title:

Department:

Telephone:

I have read and understand the above information.

Employee Signature

Date

Oregon Department of Corrections
Transitional/Modified Duty Return to Work Letter

Letter D, Off-The-Job Injury

Date:

Name:

Address:

City, State Zip:



Dear:

In accordance with DOC Policy 20.57 the Department of Corrections offers off-the-job injured employee's temporary modified duty work when it is appropriate, suitable and/or available. Your physician, Dr. _____, has released you for modified work and you have provided the Department with a conditional medical information release (Employee Medical Status Report, page 2). We have located or designed a temporary modified duty position for you, which meets your restrictions. This transitional work assignment is typically limited to a 30-day period with extensions and normally ends at a total of 90 days. The availability of this position will be periodically re-evaluated.

PLEASE NOTE: An on-the-job injured employee has a higher priority for placement in transitional assignments or temporary modified work and could displace an off-the-job injured employee if there is not sufficient work for both.

The job is: _____ See attached job description.

The rate of compensation (pay) for an off-the-job injured employee working in transitional work or modified duty shall be determined by the assigned Human Resources Manager in consultation with the employee's supervisor.

We ask that you report for work on:

Date: _____ Time: _____ (a.m. /p.m.) Shift: _____

Hours per day/week: _____ Duration of job (if known): _____

Report to: _____ Phone: _____

Location: _____

While working in this temporary modified duty assignment it is an expectation that you will follow your physician's medical restrictions.

We are looking forward to seeing you and wish you a speedy recovery.

Sincerely,

Name & Title:

Department:

Telephone:

I have read and understand the above information.

Employee Signature

Date

Oregon Department of Corrections
End of Transitional/Modified Duty

Letter E, End of Temporary Modified Duty

Date:

Name:

Address:

City, State Zip:

SAIF Claim No.:

Date of Injury:



Dear:

On day of week, month, day, year, after review and consideration of information provided by your treating physician you were offered and began a temporary modified duty work assignment. This assignment was _____.

You were informed by letter dated _____, that your limited duty assignment was for 30 day increments and it normally ends at 90 days.

On day of week, month, day, year, you will have been in this limited duty position for 90 days. As of this date we have not received a full duty release to perform the duties of your position and you will be placed on medical leave. If your medical status changes and you do receive a full unconditional release please notify us immediately so that you may return to your work assignment.

If you have any questions, please feel free to contact _____
at _____.

Sincerely,

Name & Title:

Department:

Telephone:



OREGON DEPARTMENT OF CORRECTIONS EMPLOYEE/VOLUNTEER REPORT OF INCIDENT/NEAR-MISS/INJURY/ILLNESS



FACILITY OR UNIT: _____ DATE/TIME OF INCIDENT: ____ / ____ / ____ (AM/PM)

EMPLOYEE NAME: _____ WORK PHONE: _____

(Number To Be Reached At Work)

JOB TITLE: _____ WORKING SHIFT: _____ (AM/PM) TO: _____ (AM/PM)

SCHEDULED DAYS OFF: MON. ___ TUES. ___ WED. ___ THURS. ___ FRI. ___ SAT. ___ SUN. ___

WILL YOU COMPLETE YOUR SHIFT? YES ___ NO ___ DOCTORS CARE NEEDED? YES ___ NO ___ UNSURE ___

NAME OF SUPERVISOR CONTACTED: _____

WHEN DID YOU TELL YOUR SUPERVISOR ABOUT THE INJURY/ILLNESS? DATE _____ TIME _____ (AM/PM)

WITNESSES: _____

Please check and/or circle to describe injured part of the body.			Please check for Type of Injury.		
<input type="checkbox"/> Head			<input type="checkbox"/> Abdomen		<input type="checkbox"/> Abrasion
<input type="checkbox"/> Face			<input type="checkbox"/> Back	Upper Lower	<input type="checkbox"/> Cut
<input type="checkbox"/> Eyes	Right Left		<input type="checkbox"/> Hip(s)	Right Left	<input type="checkbox"/> Puncture
<input type="checkbox"/> Neck			<input type="checkbox"/> Leg	Right Left	<input type="checkbox"/> Crush/Bruise
<input type="checkbox"/> Shoulder	Right Left		<input type="checkbox"/> Knee	Right Left	<input type="checkbox"/> Fracture
<input type="checkbox"/> Chest			<input type="checkbox"/> Ankle	Right Left	<input type="checkbox"/> Sprain/Strain
<input type="checkbox"/> Arm(s)	Right Left		<input type="checkbox"/> Foot	Right Left	<input type="checkbox"/> Dislocation
<input type="checkbox"/> Elbow	Right Left		<input type="checkbox"/> Toe(s)	Right Left	<input type="checkbox"/> Burn
<input type="checkbox"/> Hand	Right Left		<input type="checkbox"/> Broken Glasses		<input type="checkbox"/> Irritation
<input type="checkbox"/> Wrist	Right Left		<input type="checkbox"/>		<input type="checkbox"/> Occupational Illness
<input type="checkbox"/> Finger(s)	Right Left		<input type="checkbox"/>		<input type="checkbox"/> Other (list) _____
<input type="checkbox"/> Other (list)	_____		<input type="checkbox"/>		_____

WAS FIRST AID APPLIED? YES ___ NO ___ IF YES, BY WHOM: _____

LOCATION WHERE INJURY OCCURRED (building, room, etc.): _____

EMPLOYEE DESCRIPTION OF INCIDENT/NEAR-MISS/INJURY/ILLNESS (Provide complete details, including; what you were doing prior to the incident/injury/illness, what materials/objects/machines were involved, what inmates were involved, etc.)

EMPLOYEE SIGNATURE: _____ DATE: _____

**YOU MUST NOTIFY YOUR SUPERVISOR IMMEDIATELY OF THIS INJURY/ILLNESS.
IF YOU SEEK MEDICAL TREATMENT, NOTIFY YOUR SUPERVISOR and REQUEST A SAIF 801 CLAIM FORM IF
YOU INTEND TO FILE A WORKERS COMPENSATION CLAIM.
UPON COMPLETING THIS FORM, GIVE IT TO YOUR SUPERVISOR, KEEPING A COPY FOR YOUR RECORDS.**



OREGON DEPARTMENT OF CORRECTIONS SUPERVISOR'S ANALYSIS OF INCIDENT/NEAR-MISS/INJURY/ILLNESS



SUPERVISORS SHALL IMMEDIATELY CONDUCT A COMPLETE ANALYSIS OF THE INCIDENT, NEAR-MISS, INJURY, OR ILLNESS. ANALYSIS SHALL INCLUDE: TALKING WITH WITNESSES, ENVIRONMENTAL CONDITIONS OF THE WORK AREA, AND A WALK THROUGH OF THE INCIDENT WITH THE EMPLOYEE TO DETERMINE CAUSE AND TO CORRECT HAZARDOUS CONDITIONS OR UNSAFE WORK PRACTICES.

SUPERVISORS ACCOUNT OF INCIDENT: _____

- | Unsafe Acts | Unsafe Conditions |
|---|---|
| <input type="checkbox"/> Operating at Unsafe Speed | <input type="checkbox"/> Improperly Guarded Equipment |
| <input type="checkbox"/> Using Unsafe Equipment | <input type="checkbox"/> Improper Lighting |
| <input type="checkbox"/> Taking Unsafe Position | <input type="checkbox"/> Unsafe Design or Construction |
| <input type="checkbox"/> Poor Lifting Position or Placement | <input type="checkbox"/> Hazardous Exposure |
| <input type="checkbox"/> Failure to Take Precautions | <input type="checkbox"/> Hazardous Storage or Arrangement |
| <input type="checkbox"/> Failure to USE Personal Protective Equipment | <input type="checkbox"/> Defective Tools, Equipment, etc. |
| <input type="checkbox"/> Slips or Falls | <input type="checkbox"/> No Personal Protective Equipment |
| <input type="checkbox"/> Distraction | <input type="checkbox"/> Combative Inmate |
| <input type="checkbox"/> Carelessness | <input type="checkbox"/> Combative Visitor |
| <input type="checkbox"/> Other (explain) _____ | <input type="checkbox"/> Other _____ |

REASON FOR UNSAFE ACT (Lack of training, carelessness, etc.): _____

REASON FOR UNSAFE CONDITION: _____

HOW COULD THIS INCIDENT/NEAR-MISS BEEN AVOIDED: _____

WITNESS(ES) STATEMENT(S) (Attach sheets if needed): _____

CORRECTIVE ACTIONS (To prevent re-occurrence and/or correct hazardous conditions.): _____

IF YOU HAVE REASON TO BELIEVE THE INJURY **MAY NOT** BE WORK RELATED, PLEASE EXPLAIN: _____

SUPERVISORS SIGNATURE: _____ DATE: _____

IT IS THE SUPERVISORS RESPONSIBILITY TO NOTIFY THE ASSIGNED SAFETY MANAGER OF THIS INCIDENT, INJURY, and/or ILLNESS.

CC: EMPLOYEE
 IMMEDIATE SUPERVISOR
 SAFETY MANAGER



DEPARTMENT OF CORRECTIONS
Human Resources - Payroll

◆ IMPORTANT ◆
CONTINUATION OF BENEFITS EMPLOYEE NOTICE
YOU MUST RESPOND TO THIS NOTICE

MEMO TO: _____ DATE: _____

FROM: Human Resources, Payroll

SUBJECT: Continuation of Benefits

Date of Claim: _____
Delivered By: _____
Via (mail, personally, or?): _____

State law (ORS 659A.060 – 659A.069) requires the State as an employer to continue to pay the employer's contribution toward group health benefits when coverage under a State plan would otherwise end due to a workers' compensation injury or illness. Failure to continue health and dental benefits of injured or ill worker as provided under the above statute is an unlawful employment practice. This notice informs you of your obligations under the provisions of this law.

If you are eligible for continuation of coverage under the law, you will receive the coverage that you had immediately prior to your on-the-job injury or illness. The law requires that your employer's contribution for coverage be maintained for up to twelve months from the date the Department of Corrections received notice that you have filed a workers' compensation claim pursuant to ORS chapter 656. However, the law also provides that your coverage will end whichever of the following occurs first:

- Your attending physician has determined that you are medically stationary and a determination order or notice of closure has been entered;
- You return to work for any agency of the State after periods of continued coverage under this law, and satisfy any probationary or minimum work requirements to be eligible for group health benefits;
- You take full or part-time employment with a private employer other than the State of Oregon that is comparable in terms of the number of hours per week you were employed with the State, or you retire;
- Twelve months have elapsed since the date the State received notice that you filed a workers' compensation claim;
- Your claim is denied and you fail to appeal within 60 days or if you appealed, the Workers' Compensation Board, a workers' compensation hearing referee, or a court decides that your claim is not compensable;
- You do not pay the required premium, or portion thereof, in a timely manner;
- You elect to discontinue this coverage and notify your Human Resources, Payroll of this election in writing;
- Your attending physician has released you to modified or regular work, you have been offered the work and you refuse to work; or,
- You are terminated from employment for reasons unrelated to the workers' compensation claim.

- A. _____ If your employer's contribution does not cover the full cost of your group health premiums, you will be required to pay your portion to the premium to continue coverage. If you fail to make timely payment of any premium contribution owing, you will be noticed on the 30-day grace period allowed before cancellation of your coverage. Upon expiration of your coverage under State law, you may be eligible to continue coverage on a self-pay basis under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
- B. _____ If your workers' compensation claim is denied, or if you appeal and not prevail, the State may recover from you the amount of premiums paid under this law, plus interest. The State may recover the payments through a payroll deduction, not to exceed 10% of your gross pay.

If you chose not to receive continued coverage under ORS 659A.060-069, you may be eligible under Federal COBRA regulations to continue your group health coverage on a self-pay basis for up to 18 months. Premiums for coverage continued under the COBRA provisions are set at 102% of the active group rate for the first 18 months. If you are determined by Social Security to be disabled at the time you lost group health coverage, the continuation period may be extended to 29 months. If eligible for the extended coverage due to a disability, premiums 19 through 29 will be set at 150% of the active group rate. If you would like more information on COBRA contact Human Resources, Payroll.

This law does not require continuation of any life or disability programs, opt-out bonuses, or benefit dollars taken as cash. If you would like more information on how to continue life and/or disability coverage, please contact your payroll officer. You must self-pay Standard Long-Term Disability coverage throughout the elimination period to be eligible for benefits. To continue other benefit plans, such as credit union or automobile insurance, you must contact the company(s).

REINSTATEMENT OF COVERAGE WHEN YOU RETURN TO ACTIVE WORK STATUS

Please Contact Your Payroll Office Within 60 Days of Returning

**PUBLIC EMPLOYEES BENEFIT BOARD (PEBB)
I. SPONSORED PLAN-FOR ALL STATE OF OREGON EMPLOYEES**

Definition of Benefit Eligible Status-An employee must receive pay for at least 80 of the regular working hours in a month to be eligible for benefits for the following month.

- C. _____ All benefits in effect prior to qualifying for coverage under ORS 659.060-069 will be automatically reinstated. We request that you complete an Update Form to provide us with the necessary information during the first 60 days of your return to avoid retroactive adjustments and assure that coverage is reinstated promptly. Changes in elections are limited to open enrollment periods or within 60 days following a qualified family status change. If coverage under SEBB health, dental, or disability coverage lapse for 90 days or more, you may be subject to preexisting condition limitations of exclusion. See your PEBB Eligibility Handbook for more information on, qualified family status changes, preexisting condition limitations, and exclusions. Contact the Public Employees Benefit Board at 378-3964 or 1-800-788-0520 for more information.

VERY IMPORTANT

Please initial paragraphs A, B, and C, and sign, to indicate that you have received and read this document completely.

Signature

Date

**Please return to the Department of Corrections Human Resources Payroll Division.
Failure to return a signed copy could affect your coverage.**